

# OT TRENDS

Volume 10, Issue 2

Summer 1999



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## Long Term Care: Are You Ready?

It is a fact that more people are living longer lives. One result of this rise in life expectancy is the increased likelihood that some type of long term care will be needed in the future. Such care includes a range of nursing, social, and rehabilitative services for people who need ongoing assistance. Without proper planning, these long term care needs can quickly erode life savings and bring about financial havoc. Yet, planning ahead for long term care needs is not considered by many while they are young. The American Health Care Association commis-

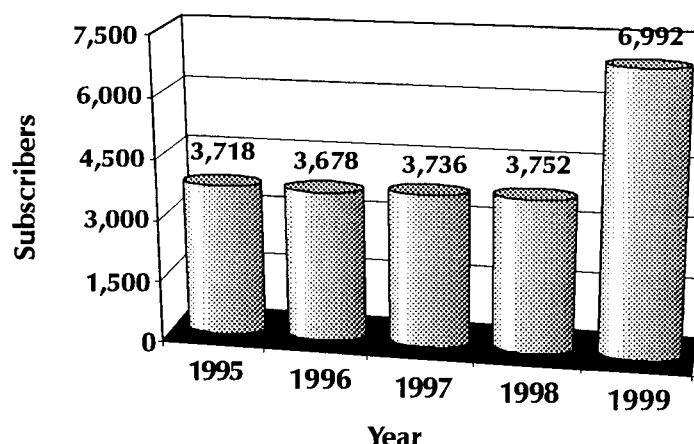
sioned a study which indicated that most of the 800 adults aged 34 to 52 surveyed are unprepared to pay for their long term care needs.



Long term care insurance is an important tool available to help meet the financial requirements of long term care. Many employers are beginning to offer employees long term care insurance benefits designed to help meet the potential need for care. According to a report released by the Health Insurance Association of America entitled "Long-Term

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## Long Term Care Enrollment Movement June 1995 through June 1999



## Long Term Care

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Care Insurance in 1996," the rate in sales of employer-sponsored policies has grown by an average 47 percent annually since 1987.

The South Carolina Budget and Control Board sponsors a long term care (LTC) plan offered by Aetna Life Insurance Company. Eligible enrollees may purchase insurance in benefit units, ranging from a daily benefit amount of \$40 to \$150 (in \$10 increments). Once a qualifying event occurs, the plan pays 100 percent of the covered person's daily benefit amount for inpatient nursing facility care. The plan pays half of the daily inpatient nursing facility care benefit for care received at home or in an adult day-care facility.

State employees, retirees, and their spouses are eligible for this plan. Parents and parents-in-law may also enroll in the LTC plan. New employees may enroll within 31 days of their hire date without medical evidence of good health. Other active employees may enroll during LTC open enrollment periods without providing medical evidence of good health or after by providing medical evidence of good health. Active spouses, parents and parents-in-law, retirees, spouses of retirees, and surviving spouses may enroll at any time by providing medical evidence of good health. Benefits are paid under the plan 90 days after a qualifying loss of function.

The lifetime maximum benefit payable is based upon a maximum of 1,825 days (5 years x 365 days per year) per \$10 unit of benefits purchased. This formula is used for any combination of

nursing facility care and/or eligible home care. For example, if you choose a \$100 daily benefit and receive all your care in a nursing facility; you may receive up to \$182,500 (\$100 x 1,825 days) over a 5-year period.

### Historical Perspective

Long-term care insurance was first offered to state, school district and other eligible entity employ-

during March 1999, only about 25 percent of LTC enrollees were less than age 50 while other plans have larger numbers of enrollees under age 50. Following the March 1999 open enrollment period, the percentage improved to about 36 percent.

The LTC plan has seen both growth and decline in enrollment over the past eight years. In 1991, average annual enrollment

### Long Term Care Enrollment Growth By Type June 1998 through June 1999

Enrollee Type	1998	1999	Amount Increase	% Increase
Active	1,706	4,550	2,844	167.0%
Active Spouse	379	562	183	48.3%
Retirees	1,256	1,405	149	11.9%
Retiree Spouse	352	386	34	9.7%
Parents	59	89	30	50.8%
<b>Total:</b>	<b>3,752</b>	<b>6,992</b>	<b>3,240</b>	<b>86.4%</b>

ees in 1988 with coverage effective January 1, 1989. Since its inception, the Aetna Life Insurance Company has underwritten the program. Initially, the daily benefit for inpatient nursing facility care ranged from \$30 to \$100 with a lifetime maximum benefit of \$182,500. These levels have increased since 1989 to the new daily benefit level ranging from \$40 to \$150 and lifetime maximum benefit of \$273,750, effective April 1, 1999.

### Enrollment

Long term care insurance enrollment continues to lag behind other types of insurance offered or sponsored by the state. One reason for this trend is the relatively low number of LTC enrollees under age 50. Prior to the recent open enrollment held

totalled 3,913 subscribers. Enrollment dropped to 3,683 subscribers in 1996 before making some gains and reaching 3,741 subscribers in 1998.

### March 1999 Open Enrollment

The March 1999 open enrollment significantly increased LTC enrollment. During this open enrollment period, employees were able to enroll in the long term care plan without providing medical evidence of good health. Persons currently enrolled in LTC as of March 1999 also benefited by being able to increase their coverage by \$10 without providing medical evidence of good health. As a result, LTC enrollment increased a dramatic 86 percent to 6,992 in June 1999

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## Long Term Care

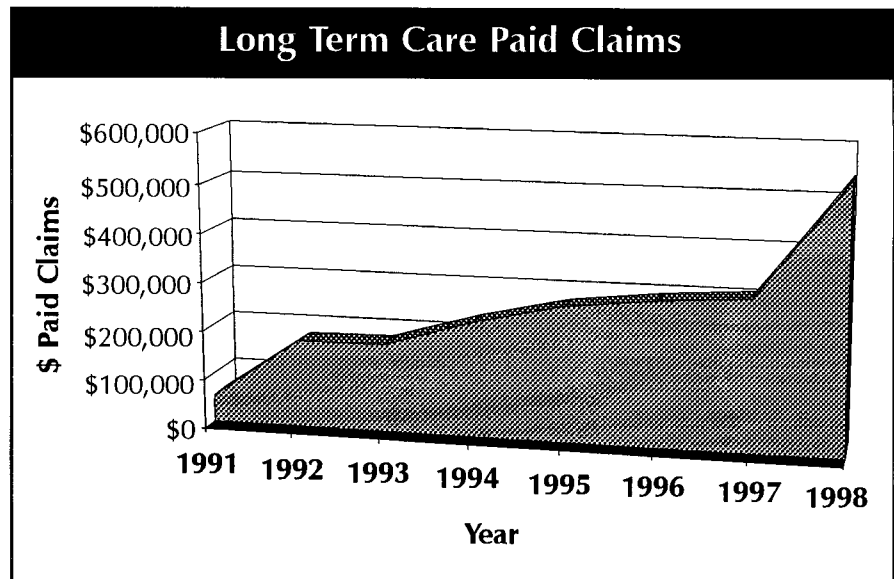
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from 3,754 enrollees in March 1999.

### Claims Payment

The amount paid in LTC claims has continued to rise annually. In 1991, a total of \$55,745 was paid for long term care claims. By 1998, the amount paid in claims had grown to \$542,800; nearly ten times the amount paid in 1991. The most significant climb in payments occurred between 1991 and 1992 when claims payments rose from \$55,745 in 1991 to \$176,950 in 1992. One reason for this increase is the fact that retirees were not eligible for coverage until January 1, 1991 and pre-existing conditions were not covered. Under LTC guidelines, any qualifying loss of functional capacity caused by a pre-existing condition beginning within the first 12 months of coverage would not be covered.

The second largest percentage growth in annual claims payments occurred between 1997 and 1998 when payments rose 77 percent from \$306,640 in 1997 to \$542,800 in 1998. With the substantial increase in LTC enrollment during 1999, annual claims payments are on track to reach a new all-time high by the end of 1999. Claims payments from January

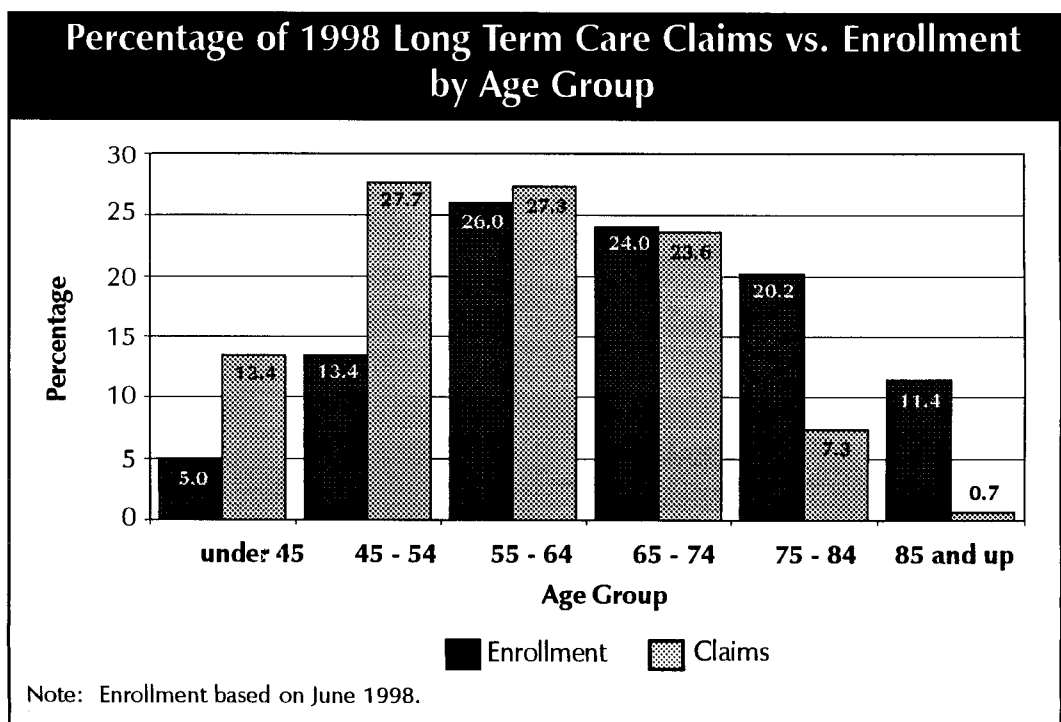


through May 1999 are 20.4 percent higher than during the same time period in 1998.

### Conclusion

As baby-boomers age, the need for long term care will continue to increase. While many remain unaware of the potential costs associated with long term care, many more have not taken

proactive steps to lessen the impact of potential long term care needs. Since premium rates are based on age at enrollment, earlier planning for long term care can help make the later years of life more enjoyable. The fact that many under age 50 eligible for coverage have not enrolled illustrates the potential for continued education and enrollment growth. T



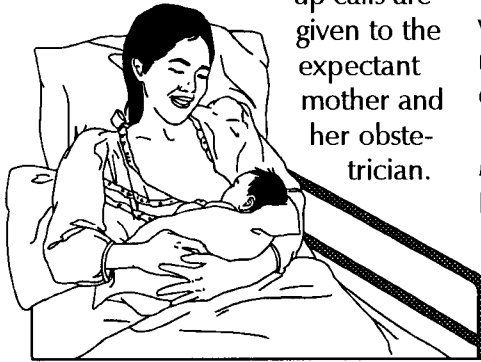
## Maternity Analysis: Newborns & Deliveries

Pregnancy is a special time for any family. It is a time when family members reflect on the past while planning for the future. Ensuring that both the expectant mother and the unborn baby receive quality health care during the pregnancy plays an important role in realizing future dreams and aspirations. Lack of proper care can lead to problems for both mother and child.

To ensure that both mother and child receive proper care, the State Health Plan (SHP) provides a full range of maternity benefits from prenatal to postpartum care, including childbirth, miscarriage and pregnancy-related complications. All covered expectant mothers are required to notify Medi-Cal, the SHP's utilization review program, of the pregnancy during the first trimester. Doing so automatically enrolls the mother-to-be in the Maternity Management Program. During

enrollment, a case management nurse will complete a Maternity Health Assessment to identify potential high risk factors during the first trimester. Based upon the results of the assessment, follow-

up calls are given to the expectant mother and her obstetrician.



Program nurses are available throughout the entire pregnancy. Failure to notify Medi-Cal during the first trimester results in a \$200 penalty, which is applied as a deductible for the hospital stay.

The SHP has established guidelines for hospital delivery stays. In accordance with federal

law, normal vaginal deliveries are covered for a hospital stay of 48 hours while a Caesarian section (C-section) is covered for a hospital stay of 96 hours. These benefits are provided to female subscribers and the dependent wives of male subscribers. No maternity benefits are provided to dependent children.

### Maternity Management Program Utilization

In 1994, participation in the Maternity Management Program was only at 52.1 percent of expectant mothers. Participation in the program became mandatory the following year, resulting in a 38.4 percent increase in participation, which rose to 90.5 percent. Since then, participation has slowly climbed to 92.8 percent in 1998.

Approximately 92.4 percent of

**Continued on page 5**

### Diagnosis Related Groups (DRGs) for Newborns

DRGs	Definition	Explanation
391	<i>Normal Newborn</i>	● newborns without any notable health problems
385	<i>Died or Transferred to Another Acute Care Facility</i>	● self-explanatory
386	<i>Extreme Immaturity or Respiratory Distress Syndrome</i>	<ul style="list-style-type: none"> <li>● newborns with respiratory distress syndrome and/or birth weight less than 1,500 grams (about 3.3 pounds)</li> <li>● most severe cases involving the longest stays and highest charges</li> </ul>
387	<i>Prematurity with Major Problems</i>	● birth weights between 1,500-2,500 grams (3.3 to 5.5 pounds) and at least one of a number of specified serious medical difficulties
388	<i>Prematurity without Major Problems</i>	● cases with the diagnosis of immaturity (1,500-2,500 grams), but without the specified problems listed for DRG 387
389	<i>Full Term Neonate with Major Problems</i>	● infants with one of the major problems specified for DRG 387, but without the immaturity diagnosis
390	<i>Neonate with Other Significant Problems</i>	● cases with problems not specified on the list that would otherwise classify the admission as DRG 387

## Maternity

Continued from page 4

the mothers who had vaginal deliveries in 1998 participated in the Maternity Management Program. Of the mothers having C-section deliveries, 93.8 percent participated in the program. Data also shows that 80.5 percent of expectant mothers enrolled in the program during the first trimester of their pregnancy. About 4.1 percent of mothers enrolled during the second trimester while 8.1 percent enrolled during the third trimester.

With an established goal of 100 percent participation, reasons for incomplete participation may include a continuing lack of knowledge and understanding about the program.

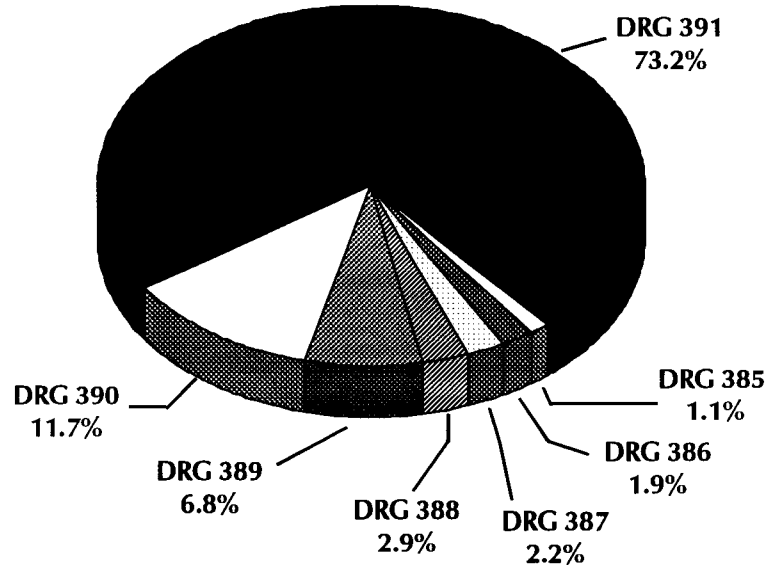
## Newborn Statistics

The outcomes of newborns born in 1998 and covered under the SHP were analyzed by DRG. A DRG is a classification group for patient diagnoses demonstrating similar resource consumption and length-of-stay patterns. Seven DRG codes relate solely to newborns. The most often cited group, DRG 391, *Normal Newborn*, includes newborns without any notable health problems. DRGs 385 through 390 include newborns with varying problems.

DRG 385, *Died or Transferred to Another Acute Care Facility*, is self-explanatory. Newborn admissions classified under DRG 385 averaged \$21,504 in charges and \$19,414 in reimbursements with an 8.8 days average length of stay. The category accounted for only 1.1 percent of 1998 newborn admissions.

DRG 386, *Extreme Immaturity*

## 1998 State Health Plan Newborn Distribution of Admissions by DRG: 1998



or *Respiratory Distress Syndrome of Neonate*, includes newborns with respiratory distress syndrome and/or birth weight less than 1,500 grams (about 3.3 pounds). These newborns, making up 1.9 percent of 1998 newborn admissions, are the most severe cases and involve the longest hospital stays and the highest charges. In 1998, their average length of stay was about 30.4 days with an average charge of \$66,776 per admission. Reimbursements for these newborns averaged \$45,415 per admission in 1998.

DRG 387, *Prematurity with Major Problems*, includes infants born weighing 3.3 to 5.5 pounds and at least one of a number of specified serious medical problems. With an admission average length of stay of 17.4 days, these newborns averaged \$27,265 in charges and \$17,083 in reimbursements per admission. Some 2.2 percent of 1998 newborn admissions were attributable to

DRG 387.

DRG 388, *Prematurity without Major Problems*, consists of cases with the diagnosis of immaturity (3.3 to 5.5 pounds), but without the specified problems listed for DRG 387. These newborns, composing 2.9 percent of 1998 newborn admissions, had an average charge of \$2,899 per admission. Reimbursements averaged \$2,738 per admission while the average hospital stay was 3.6 days.

DRG 389, *Full Term Neonate with Major Problems*, is comprised of infants with one of the major problems specified for DRG 387, but without the immaturity diagnosis. These newborns made up 6.8 percent of 1998 newborn admissions. Admission charges for these newborns averaged \$7,952 while reimbursements averaged \$4,241 per admission. The average hospital stay was 4.7 days.

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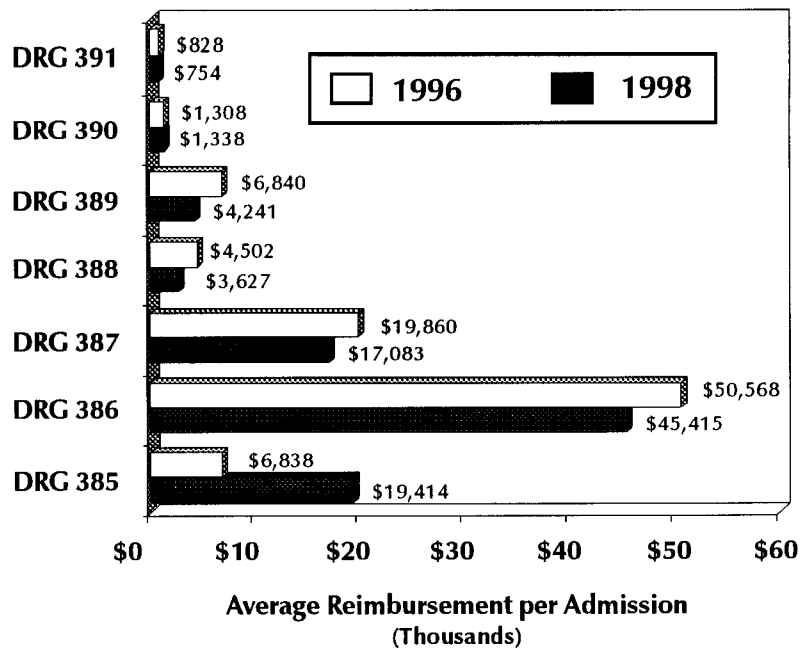
## Maternity

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DRG 390, *Neonate with Other Significant Problems*, classifies cases with problems not specified on the list that would otherwise classify the admission as DRG 387. The group was second only to DRG 391, *Normal Newborns*, in newborn admissions (11.7 percent of 1998 newborn admissions), average length of stay, and average charges. Average admission charges were \$1,491 and average reimbursements were \$1,338 per admission. These newborns averaged 2.3 days stay in the hospital.

Normal newborns are classified under DRG 391. In 1998, these newborns average length of stay was 2 days. That year, 73.2 percent of all newborn admissions in 1998 were classified as normal newborns. This is up from 1995 when 71.5 percent of newborn admissions were classified under DRG 391. Average charges per admission also rose while average

## Average Reimbursement per Admission for State Health Plan Newborn DRGs: 1996 & 1998



reimbursements per admission declined from their 1996 averages for normal newborns. In 1998, normal newborns averaged \$989 in charges (up from \$918 in 1996) and \$754 in reimbursements

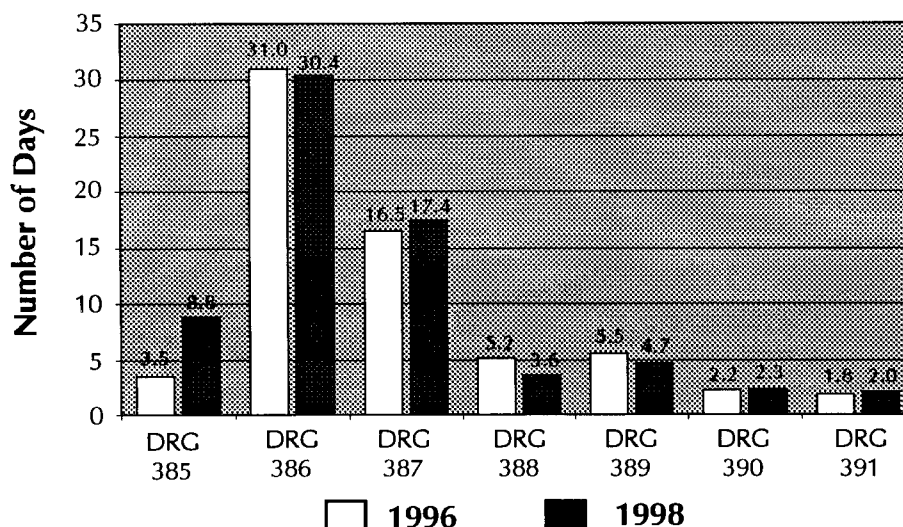
(down from \$828 in 1996) per admission.

## Delivery Statistics

While it is a fact that most women deliver babies through vaginal delivery, many continued to be delivered by C-section. Typically, mothers having C-sections have higher inpatient delivery charges with longer stays. In 1998, average inpatient delivery charge per C-section admission was \$6,780, some 72 percent higher than the \$3,950 average inpatient delivery charge per vaginal delivery admission. Average reimbursement per C-section admission

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## 1998 State Health Plan Newborns Average Length-of-Stay (LOS)



## Maternity

Continued from page 6

was \$4,025 while the average for vaginal deliveries was \$3,562 per admission. Mothers delivering babies through C-sections in 1998 averaged 3.5 days per hospital stay while vaginal deliveries averaged 2.1 days per hospital stay.

The SHP pays hospitals the same amount for non-complicated vaginal and non-complicated C-section deliveries. However, the charges and payments for complicated deliveries vary. Those mothers having C-sections and experiencing complications had the longest average length of stay in comparison to other classifications for C-section and vaginal delivery with an average length of stay of 4.4 days and an average charge of \$8,458 with an average reimbursement of \$5,696 per admission. Mothers delivering through C-sections without complications averaged 3.1 days length of stay and an average charge of \$6,122 and reimbursement of \$3,370 per admission.

## Conclusion

Obtaining proper health care during pregnancy leads to healthier newborns along with lower inpatient expenses. Normal newborns have lower inpatient charges than all other newborn classifications. Mothers delivering newborns through vaginal delivery generally spend less time in the hospital than those having C-sections. The SHP remains committed to encouraging proper maternity management throughout the pregnancy process. The benefits of such care last a lifetime. **T**

## Did You Know...

### Dependent Student Enrollment Is On The Rise

The number of college-age students covered as dependents under the State Health Plan (SHP) is increasing. February enrollment statistics from 1995 to 1999 indicate a 26.6 percent increase in dependent student enrollment since February 1995.

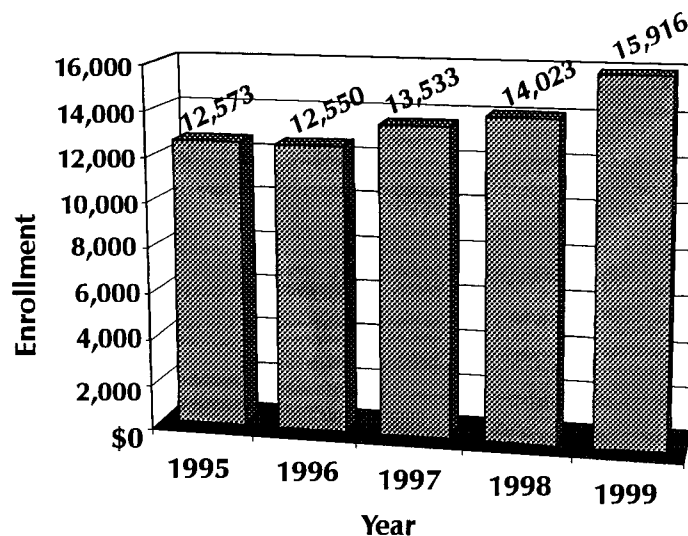
Dependent student enrollment grew 13.5 percent from February 1998 to February 1999, the largest annual growth since the 8.7 percent increase from 1994 to 1995. Since

Under SHP guidelines, dependent children ages 19 through 24 who are full-time students may be covered. If the

child is covered as a full-time student, his eligibility for coverage ends the month he turns age 25. The child's eligibility for coverage also ends if he gets married or obtains employment with benefits. OIS randomly conducts audits of enrolled dependents ages 19 through 24. Failure to verify the dependent student's status will result in termination of an ineligible dependent's coverage and may result in recoupment of benefits paid for the ineligible dependent. Failure to report changes in eligibility of dependent students may also result in penalties.



### State Health Plan Dependent Students Enrollment



## New Options Plan Offered to MUSC Employees for '99

The Medical University of South Carolina is South Carolina's largest state-supported medical university. Located in Charleston, South Carolina, the Medical University of South Carolina (MUSC) serves the state with a medical center and six colleges for the education of a variety of health related professionals. The 596-bed medical center consisting of four hospitals — Medical University Hospital, MUSC Children's Hospital, Strom Eye Institute and the Institute of Psychiatry along with several centers for specialized care make MUSC a leading health care provider in South Carolina and in the region.

Meeting the varying health care needs of the MUSC's workforce is important to the university's overall success. In 1998, a total of 6,336 MUSC active employees were covered under a state-sponsored health care plan. MUSC employees can choose from any of the state-sponsored health plans in order to meet their needs.

### The Plan

Beginning in January 1999, MUSC active employees could

select the new MUSC Options Plan for health care coverage. MUSC Options Plan is a managed care program, known as a Point-of-Service (POS) plan, designed to incorporate managed care features with out-of-network benefits. Companion Health Care is the plan's administrator. In addition to the features of traditional health insurance plans, the plan also covers other services such as annual physicals, annual

MUSC Options Plan network hospitals. The MUSC Options hospital network consists of four hospitals: East Cooper Regional Medical Center, the Medical University of South Carolina, Summerville Medical Center, and Trident Medical Center. The plan covers 60 percent of allowable charges provided at non-network hospitals.

The plan also has an unlimited lifetime maximum benefit

**1999 MUSC Options Plan Premium Comparison**

	MUSC Options	SHP* Standard	SHP* Econ	Healthsource HMO	Companion HMO	HMO Blue
<b>Employee</b>	15.28	14.72	11.70	48.58	26.48	30.04
<b>Employee/Spouse</b>	91.90	97.02	77.56	169.44	123.04	203.14
<b>Employee/Child</b>	59.80	51.74	41.32	140.52	101.52	110.60
<b>Family</b>	119.54	142.14	113.64	270.16	206.84	292.44
* State Health Plan						

pap smears, well child care and vision screenings for low copayments.

The MUSC Options plan provides enrollees services without any annual deductible. Enrollees are responsible for varying copayments which are dependent upon the place and type of services rendered. In general, copayments are lower when network providers are utilized and services are provided with referrals.

Hospital charges are covered at 100 percent when provided by

amount. In comparison, both the State Health Plan and HMO options available to MUSC employees all have a lifetime maximum benefit of \$1 million.

### Eligibility

MUSC Options Plan's service area is limited. Subscriber enrollment in the MUSC Options plan is restricted to active MUSC employees living in Charleston, Dorchester, or Berkeley counties. Dependent students living outside

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## MUSC Options

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of the Charleston area must return home to receive the maximum benefit for all health care services unless emergency or urgent services are needed.

### Premiums

Premiums for the MUSC Options plan are based upon a four-tier premium structure and are comparable to those of the State Health Plan's (SHP) Standard Plan. An active employee opting for the MUSC Options Plan pays a monthly premium of \$15.28 for employee only coverage while the same employee would pay a monthly premium of \$14.72 for employee only coverage under the SHP. Full family premium rates are lower under the MUSC Options Plan (\$119.54) than the SHP Standard Plan (\$142.14).

Since both SHP options (Standard and Economy) are comparable to the MUSC Options plan in premium rates, the MUSC Options plan appealed to some MUSC employees with the potential to realize greater savings in out of pocket costs.

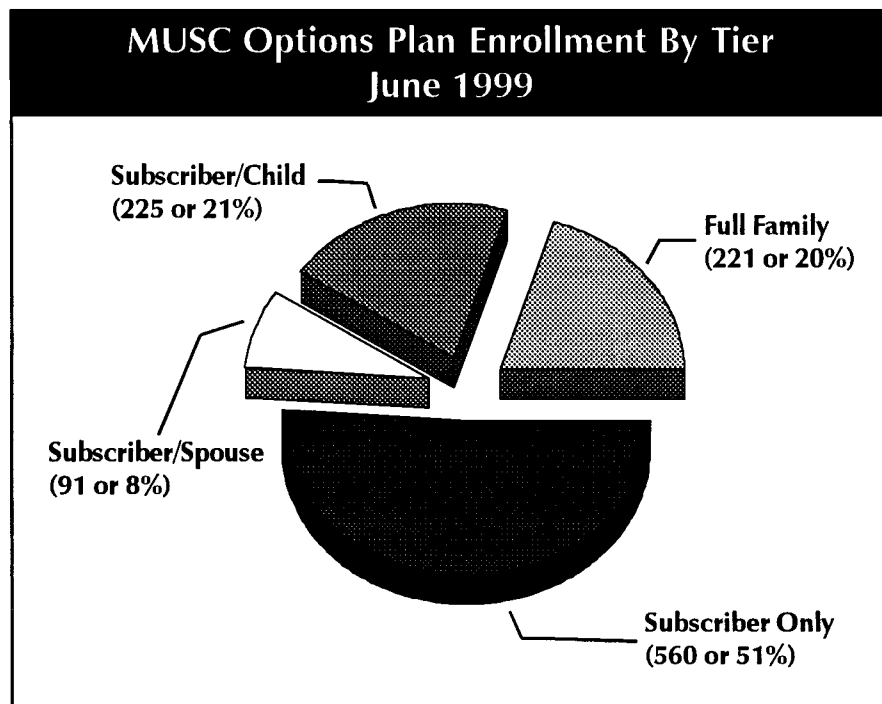
### Subscriber Enrollment

In June of 1999, the MUSC Options Plan had 1,097 subscribers. Prior to the implementation of the MUSC Options plan, most MUSC active employees chose the State Health Plan for health care coverage. In June 1998, 84.2 percent of MUSC's active employ-

ees enrolled in an employer-offered health plan chose the SHP. With the inception of the MUSC Options plan, the percentage of MUSC active employees enrolled in the SHP declined to 73.4 percent.

Statistics show that over half (57.8 percent) of MUSC Options plan's 1999 enrollment is due to subscribers (634 subscribers) switching from the SHP to the

percentage had declined to 10.4 percent. While overall MUSC active subscriber enrollment in health plans declined by 12.9 percent, HMO enrollment among active MUSC subscribers dropped by 31.4 percent from June 1998 to June 1999. Most (53.1 percent) HMO subscribers switching to the MUSC Options plan switched from the Healthsource HMO.



### Conclusion

MUSC Options Plan provides MUSC employees with a viable alternative to the State Health Plan and HMO options available to them. With its innovative approach to providing healthcare, the MUSC Options plan benefits increase substantially when utilized within the plan's

limited coverage area and through network providers. The potential for subscribers to realize out of pocket savings exists through the plan.

The plan seems to have attracted a greater percentage of MUSC's active HMO subscribers than SHP. Although more of MUSC Options plan's actual subscribers switched from the SHP, the plan's impact on the MUSC's HMO subscriber population was greater.

## 1998 State Health Plan Childhood Hospitalizations

Children are nothing less than special gifts. They make us smile and remind us of how much fun life can be. However, when a child becomes ill and requires hospitalization, it can be a tough situation for any family. With medical advances and research into childhood diseases, it is becoming less likely that children will need inpatient care during their childhood years. Yet, with all that has been accomplished, many children still require such care for various reasons. According to the American Academy of Pediatrics, over three million children are hospitalized annually in the United States. With this in mind, we examined 1998 State Health Plan (SHP) hospital claims for dependent children ages 2

through 18 to identify the causes of inpatient stays.

A total of 1,241 children ages 2 through 18 covered under the SHP were hospitalized during 1998.

### DRG Analysis

In order to examine childhood hospitalizations, DRG (Diagnostic Related Groupings) codes were utilized. A DRG is a classification group for patient diagnoses demonstrating similar resource consumption and length-of-stay patterns. The data showed that *DRG 91, Simple Pneumonia & Pleurisy, Age 0-17*, and *DRG 184, Esophagitis, Gastroenteritis and Misc. Digestive Disorders* were the two most likely diagnostic codes cited for childhood hospital-

izations in 1998.

*DRG 91, Simple Pneumonia & Pleurisy, Age 0-17* made up 7.8 percent of annual childhood hospitalizations with 127 hospitalizations totaling about \$604 thousand in covered charges. Childhood pneumonia is an inflammation of the lungs in which symptoms vary based upon cause and severity. Viruses most often cause childhood pneumonia. Pleurisy is an inflammation of the pleural lining with subsequent pain.

*DRG 184, Esophagitis, Gastroenteritis and Misc. Digestive Disorders* also composed 7.8 percent of 1998 childhood hospitalizations. The DRG's

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### 1998 Childhood Hospitalizations Top 15 DRGs

RANK	DRG	Description	Total Episodes	Covered Charges	Average Covered \$	Average LOS*
1	91	Simple Pneumonia & Pleurisy Age 0-17	127	\$603,698	\$4,754	3
2	184	Esophagitis, Gastroenteritis and Misc. Digestive Disorders Age 0-17	127	\$362,180	\$2,852	2
3	430	Psychoses	124	\$889,399	\$7,173	7
4	98	Bronchitis & Asthma Age 0-17	115	\$467,243	\$4,063	3
5	298	Nutritional and Misc. Metabolic Disorders Age 0-17	66	\$291,280	\$4,413	3
6	431	Childhood Mental Disorders	63	\$351,080	\$5,573	8
7	26	Seizure & Headache Age 0-17	56	\$249,919	\$4,463	3
8	167	Appendectomy without Complicated Principal Diagnosis without CC	55	\$374,783	\$6,814	2
9	422	Viral Illness and Fever of Unknown Origin Age 0-17	36	\$133,210	\$3,700	3
10	426	Depressive Neuroses	33	\$164,451	\$4,983	5
11	295	Diabetes Age 0-35	32	\$184,253	\$5,758	4
12	70	Otitis Media & URI Age 0-17	29	\$83,973	\$2,896	2
13	3	Craniotomy Age 0-17	25	\$533,238	\$21,330	5
14	322	Kidney and Urinary Tract Infection Age 0-17	23	\$102,424	\$4,453	3
15	410	Chemotherapy	22	\$231,763	\$10,535	3
<b>Total Top 15</b>			933	\$5,022,896	\$5,384	4
<b>Total Overall</b>			1,629	\$14,102,671	\$8,657	4

## Child Hospitalization

Continued from page 10

covered charges totaled \$362 thousand.

The third most frequently coded DRG for childhood hospitalizations was *DRG 430, Psychoses*. These are severe mental disorders caused by physical or emotional sources. In 1998, 124 hospitalizations (7.6 percent) were due to psychoses with \$889 thousand in covered charges, the annual high for covered childhood hospital charges.

### Length of Stays

Generally speaking, the shorter the hospital stay for a child, the better. In 1998, hospitalized children had an average length of stay of 4 days. The length of stays varied depending upon the DRG. For instance, those hospitalized for bone marrow transplants had the longest average length of stay, averaging 42 days per hospitalization. Children suffering spinal disorders and injuries averaged 37 days in the hospital per admittance.

As expected, children hospitalized longer had higher average covered charges. Children hospitalized an average of 1 to 13 days had an average coverage charge of \$7,731 in 1998. At the same time, children hospitalized longer than 13 days averaged \$54,882 in covered charges per hospitalization.

### Re-Hospitalization

A total of 223 children, 18 percent of 1998 hospitalized children, were hospitalized more than once in 1998. These children's combined hospital

## Top 5 1998 Childhood Hospitalizations DRGs By Average Lengths of Stay

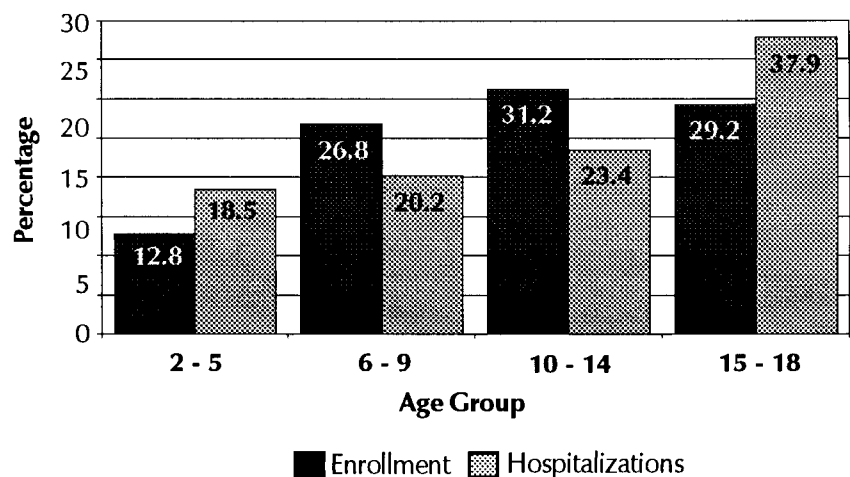
DRG	Description	Avg. Length of Stay
<b>DRG 481</b>	<i>Bone Marrow Transplant</i>	42 Days
<b>DRG 9</b>	<i>Spinal Disorders &amp; Injuries</i>	37 Days
<b>DRG 483</b>	<i>Tracheostomy Except for Face, Mouth, and Neck Diagnoses</i>	34 Days
<b>DRG 205</b>	<i>Liver Disorder Except Malignancy, Cirrhosis &amp; Alcoholic Hep. w/CC</i>	32 Days
<b>DRG 462</b>	<i>Rehabilitation</i>	27 Days

charges made up 47.9 percent of the annual total of all hospitalized children ages 2 through 18. Of this group, the two most often cited DRGs were *DRG 430, Psychoses* (79 hospitalizations) and *DRG 98 Bronchitis & Asthma Age 0-17* (40 hospitalizations). Children hospitalized multiple times also had a longer average length of stay per hospitalization (6 days per admittance) than those hospitalized only once (4 days per admittance) in 1998.

### Conclusion

Children may require hospitalization for many reasons. Minimizing the need for hospitalizations remains a goal of both parents and the State Health Plan. Through education and preventive measures such as maintaining proper diets, timely immunizations and physician office visits, the need for childhood hospitalizations will decline.

## Percentage of 1998 Childhood Hospital Claims vs. Enrollment by Age Group



Note: Enrollment based on June 1998.



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Estela L. Long, Ph.D.

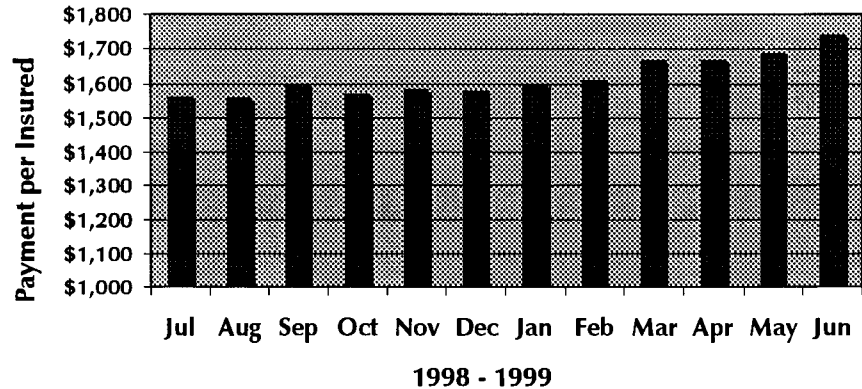
Rob Tester

Total printing cost = \$384.00; Total number  
printed = 500; Unit cost = \$0.77.

## Past Trends

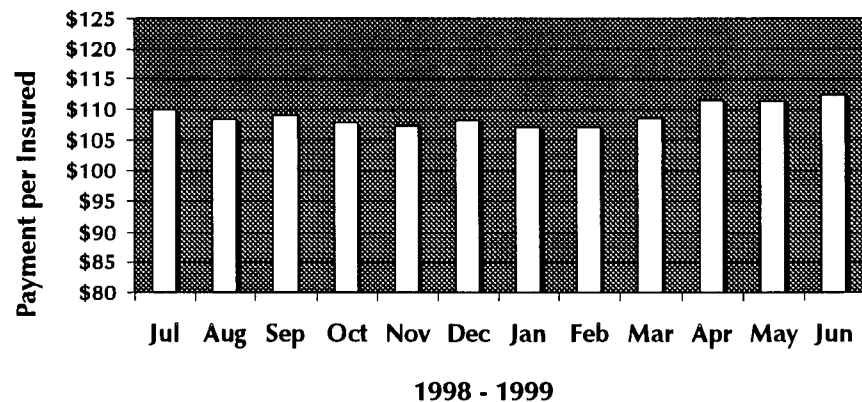
### Medical Payments in Prior Year Ending in Month Listed

*For example, the July total equals payments made August 1998 - July 1999.*



### Dental Payments in Prior Year Ending in Month Listed

*For example, the July total equals payments made August 1998 - July 1999.*



Office of Insurance Services  
State Budget and Control Board  
Post Office Box 11661  
Columbia, South Carolina 29211

ADDRESS CORRECTION REQUESTED